Print

HEALTH INSURANCE DISCLOSURE AFFIDAVIT

FRANKLIN COUNTY COMMON PLEAS COURT
DIVISION OF DOMESTIC RELATIONS AND JUVENILE BRANCH

_____
PLAINTIFF / PETITIONER

SS# _____

DOB: _____

ADDRESS: _____

_____

_____
DEFENDANT / PETITIONER

SS# _____

DOB: _____

ADDRESS: _____

_____

CASE NUMBER _____

COURT DATE _____

CHILDREN SUBJECT TO SUPPORT ORDER:

NAME: _____ DOB: _____

SS#:_____

NAME: _____ DOB: _____

SS#:_____

NAME: _____ DOB: _____

SS#:_____

NAME: _____ DOB: _____

SS#:_____

NAME: _____ DOB: _____

SS#:_____

INSTRUCTIONS PART I:

Please disclose all requested information as it pertains to you

YOUR NAME: _____ EMPLOYER:_____

EMPLOYER ADDRESS: _____ EMPLOYER PHONE: _____

_____

ARE YOU CURRENTLY RECEIVING MEDICAID? ____ YES ___ NO / MEDICARE? _____ YES _____ NO

DO YOU HAVE FAMILY HEALTH INSURANCE AVAILABLE EITHER THROUGH YOUR EMPLOYER OR ANOTHER GROUP OR ORGANIZATION? ____YES ___ NO

IS COVERAGE PRESENTLY IN EFFECT? ____YES ___NO

WHO IS PRESENTLY COVERED? _____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____RELATIONSHIP _____

_____ RELATIONSHIP _____

INSURER _____ PHONE _____

ADDRESS _____ POLICY/ GROUP #_____

_____

DO YOU PAY A PREMIUM FOR COVERAGE? _____ YES _____ NO

WHAT IS THE PREMIUM FOR FAMILY COVERAGE? $_____ PER month/year (circle one)

WHAT IS THE PREMIUM FOR INDIVIDUAL COVERAGE? $_____ PER month/year (circle one)

HEALTH INSURANCE DISCLOSURE AFFIDAVIT

IS A HEALTH INSURANCE CARD AVAILABLE? _____ YES _____ NO

ARE INSURANCE CARDS REQUIRED FOR SERVICES? _____ YES _____ NO

DOES YOUR PLAN COVER HOSPITALIZATION? _____ YES _____ NO

IS THERE A DEDUCTIBLE FOR SERVICES? _____ YES _____ NO

IF YES, WHAT IS THE DEDUCTIBLE? $_____ per VISIT/MONTH/YEAR (circle one)

IS THERE A CO-PAYMENT REQUIRED? _____ YES _____ NO

IF YES, WHAT IS THE CO-PAYMENT? $_____ per VISIT/MONTH/YEAR (circle one)

DOES YOUR PLAN COVER DOCTOR VISITS? _____ YES _____ NO

IS THERE A DEDUCTIBLE FOR SERVICES? _____ YES _____ NO

IF YES, WHAT IS THE DEDUCTIBLE? $_____ per VISIT/MONTH/YEAR (circle one)

IS THERE A CO-PAYMENT REQUIRED? _____ YES _____ NO

IF YES, WHAT IS THE CO-PAYMENT? $_____ per VISIT/MONTH/YEAR (circle one)

IS A PRESCRIPTION CARD AVAILABLE? _____ YES _____ NO

IS THERE A CO-PAYMENT REQUIRED? _____ YES _____ NO

IF YES, WHAT IS THE CO-PAYMENT? $_____ per PRESCRIPTION

DOES YOUR PLAN INCLUDE DENTAL COVERAGE? _____ YES _____ NO

DOES YOUR PLAN INCLUDE VISION COVERAGE? _____ YES _____ NO

IS COBRA COVERAGE AVAILABLE? _____ YES _____ NO
(COVERAGE AVAILABLE TO YOU AFTER TERMINATION OF EMPLOYMENT OR MARRIAGE)

IF YES, AT WHAT COST TO YOU? $_____ per MONTH/YEAR (circle one)

INSTRUCTIONS PART II:

Please disclose all requested information as it pertains to the other party

NAME OF OTHER PARTY: _____EMPLOYER:_____

EMPLOYER ADDRESS: _____ EMPLOYER PHONE: _____

_____

IS HE/SHE CURRENTLY RECEIVING MEDICAID? ____ YES ___ NO / MEDICARE? _____ YES _____ NO

DOES HE/SHE HAVE FAMILY HEALTH INSURANCE AVAILABLE EITHER THROUGH HIS/HER EMPLOYER OR ANOTHER GROUP OR ORGANIZATION? ____YES ___ NO

IS COVERAGE PRESENTLY IN EFFECT? ____YES ___NO

WHO IS PRESENTLY COVERED? _____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____RELATIONSHIP _____

_____ RELATIONSHIP _____

HEALTH INSURANCE DISCLOSURE AFFIDAVIT

INSURER _____ PHONE _____

ADDRESS _____ POLICY/ GROUP #_____

_____

DOES HE/SHE PAY A PREMIUM FOR COVERAGE? _____ YES _____ NO

WHAT IS THE PREMIUM FOR FAMILY COVERAGE? $_____ PER month/year (circle one)

WHAT IS THE PREMIUM FOR INDIVIDUAL COVERAGE?$_____ PER month/year (circle one)

IS A HEALTH INSURANCE CARD AVAILABLE? _____ YES _____ NO

ARE INSURANCE CARDS REQUIRED FOR SERVICES? _____ YES _____ NO

DOES HIS/HER PLAN COVER HOSPITALIZATION? _____ YES _____ NO

IS THERE A DEDUCTIBLE FOR SERVICES? _____ YES _____ NO

IF YES, WHAT IS THE DEDUCTIBLE? $_____ per VISIT/MONTH/YEAR (circle one)

IS THERE A CO-PAYMENT REQUIRED? _____ YES _____ NO

IF YES, WHAT IS THE CO-PAYMENT? $_____ per VISIT/MONTH/YEAR (circle one)

DOES HIS/HER PLAN COVER DOCTOR VISITS? _____YES _____ NO

IS THERE A DEDUCTIBLE FOR SERVICES? _____ YES _____ NO

IF YES, WHAT IS THE DEDUCTIBLE? $_____ per VISIT/MONTH/YEAR (circle one)

IS THERE A CO-PAYMENT REQUIRED? _____ YES _____ NO

IF YES, WHAT IS THE CO-PAYMENT? $_____ per VISIT/MONTH/YEAR (circle one)

IS A PRESCRIPTION CARD AVAILABLE? _____ YES _____ NO

IS THERE A CO-PAYMENT REQUIRED? _____ YES _____ NO

IF YES, WHAT IS THE CO-PAYMENT? $_____ per PRESCRIPTION

DOES HIS/HER PLAN INCLUDE DENTAL COVERAGE? _____ YES _____ NO

DOES HIS/HER PLAN INCLUDE VISION COVERAGE? _____YES _____ NO

IS COBRA COVERAGE AVAILABLE? _____ YES _____ NO
(COVERAGE AVAILABLE TO HIM/HER AFTER TERMINATION OF EMPLOYMENT OR MARRIAGE)

IF YES, AT WHAT COST TO HIM/HER? $_____ per MONTH/YEAR (circle one)

SIGNATURES MUST BE NOTARIZED

_____ _____

AFFIANT ATTORNEY FOR AFFIANT

_____

SUPREME COURT NUMBER

SWORN TO ME AND SUBSCRIBED IN MY PRESENCE,

THIS _____DAY OF _____, 20___

_____

NOTARY PUBLIC